Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005023	A. BUILDING _____ B. WING _____	06/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAM N WISHARD MEMORIAL HOSPITAL	1001 W 10TH ST INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of a licensure complaint. Survey Type: Licensure complaint IN00103129: Unsubstantiated, lack of sufficient evidence. Date of Survey: 06-12-12 Facility number: 005023 Surveyors: John Lee, R.N. Public Health Nurse Surveyor William N Wishard Memorial Hospital is in compliance with 410 IAC 15-1.5-6, Nursing service, Hospital Licensure Rules. QA: claughlin 06/19/12	S 000		